Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C B. WING JL6012835 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE **ROSEWOOD CARE CENTER OF JOLIET JOLIET, IL 60435** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Statement of Licensure Violations Investigation of complaint Number 1971965/IL110505 S9999 Final Observations S9999 Statement of Licensure Violations Investigation of complaint Number 1971965/IL110505 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually Attachment A by this committee, documented by written, signed and dated minutes of the meeting. Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 04/11/19

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C	
		IL6012835	B. WING		03/22/2019	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSEW	OOD CARE CENTER	OF JOLIET 3401 HEN JOLIET, II	INEPIN DRI\ L 60435	/E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
S9999	Continued From page 1		S9999			
	b) The facility: care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal or resident to meet the care needs of the re-	shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident. Restorative ude, at a minimum, the				
		Abuse and Neglect censee, administrator, of a facility shall not abuse or				
	These Regulations by:	were not met as evidenced			:	
	interview the facility policy to use two sta	on, record review, and failed to follow the facility's aff members while transferring nechanical lift. This resulted in	17			

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6012835 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE **ROSEWOOD CARE CENTER OF JOLIET** JOLIET, IL 60435 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 R1 sustaining an acute fracture of distal humerus. This applies to 1 of 3 residents (R1) reviewed for accidents in the sample of 3. Findings include: The Face Sheet documents R1 is 78 years old and has diagnoses including muscle wasting and atrophy, flaccid hemiplegia affecting right dominant side, senile dementia, breast cancer and cerebral vascular disease. The Minimum Data Set (MDS) dated 3/10/19 shows R1 has a BIMS (Brief Interview for Mental Status) score of 7 out of 15 indicating cognitive impairment; is totally dependent on staff for transfers (full staff performance every time) requiring two person physical assistance; has impairment in upper and lower extremity on one side; and is only able to stabilize with staff assistance during surface-to-surface transfer. The Care Area Assessment (CAA) dated 9/12/18 triggered risk factors for ADL (Activities of Daily Living) Functional Status as CVA (Cerebral Vascular Disease), hemiplegia, limited range of motion, impaired coordination, impaired balance, muscular atrophy and increased weakness/decreased strength. Care plans read: 8/29/18: Fracture of right humerus; transfers will be completed by the staff with mechanical lift as required, Goal date 3/17/19: Intervention- direct staff in-servicing re: proper positioning of mechanical lift pads and wheelchair positioning. Require assistance to transfer with mechanical lift secondary to altered mental status, CVA, right sided hemiparesis; Goal date- 3/17/19; Intervention- Transfer guest per

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6012835 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE **ROSEWOOD CARE CENTER OF JOLIET JOLIET, IL 60435** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 resident care card (located in resident's closet). 9/18/18: R1 is totally dependent on staff; Goal date- 3/17/19; Intervention- Provide proper assistance for transfers/ protect extremities to decrease risk of injury. 12/21/18 Bruise/swelling noted to hand and wrist: Intervention- CNA in-serviced via phone re: body proximity during transport. The facility Incident/Accident Report dated 3/19/19 documents V5 (Certified Nursing Assistant/CNA) stated R1 complained of pain to the right arm when attempting to place it on a pillow. Nursing Notes dated 3/19/19 at 9:30 AM reads: Guest complained of right arm pain when staff attempted to place arm on pillow while in bed. Right sided hemiplegia per history. The Transfer Form documents: R1 transferred to the hospital on 3/19/19 for pain/right arm fracture. The Radiology Report dated 3/19/19 reads: Right Humerus 2+ Views Indication-pain Impression- Acute fracture of the distal humerus. The Incident/Accident Witness Statement by V5 reads: Describe what you heard:- I moved R1's right arm and R1 complained of pain. Where did you last observe this resident and what were they doing?:- I was providing direct care at the time of complaint of pain. No knowledge of any incident prior to care. No complaint of pain earlier. Incident Investigations read:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A SUM DATE CONSTRUCTION (X3) DATE SURVEY COMPLETED.

	IL6012835	B. WING	C 03/22/2019
AND FLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING;	COMPLETED

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KOSEW	OOD CARE CENTER OF JOLIET	JOLIET, II		_	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
S9999	Continued From page 4	· · · · · ·	S9999		
	Fracture to right distal humerus. X-R fracture What are the resident's remarks regaincident? - "My arm is broken."				
	Staff Interviews on 3/21/19 at 1:46 PN she was the caregiver for R1 on 3/19, complained of arm pain. V5 stated "I (R1) all morning. (R1) did not complaint until I put (R1) to bed. Prior to that, nowas up in the recliner chair. I put (R1 was just myself." V5 stated she transivia mechanical lift by herself. When a policy for mechanical lift transfers, V5 should be 2 people. I couldn't find an me. (R1) does not complain of pain very (Activities of Daily Living), no arm pain put (R1) back to bed, (R1) said (R1's) V5 also stated "(R1) does not use (R1 arm. (R1) did say it's broken when I a hurts. I don't know what (R1) meant (R1) does not help at all with transfers asked how she knows what care interin place, V5 replied "They should have in the closet on the door." When asked R1's care card, V5 stated "I didn't look stated interventions for R1 included "r lift with 2 people. (R1) does not ever care." V5 stated she started work at 83/19/19 and R1 did not complain of page 100 AM during care.	/19 when R1 took care of ain of pain. (R1)) to bed. It iferred R1 asked the freplied "It yone to help with ADLs in. When I arm hurts." I's) right asked if it by that. is." When eventions are exare cards about it." V5 mechanical refuse 6:00AM on			
	On 3/21/19 at 2:02 PM, V6 (Nurse) stawas the nurse on duty 3/19/19 when wher that R1 was complaining of arm postated "I last saw (R1) in the dining room onitoring the dining room from 8:00 (R1) had no complaints of pain. (R1's	/5 informed ain. V6 om. I was -9:00 AM.			

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6012835 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE **ROSEWOOD CARE CENTER OF JOLIET JOLIET, IL 60435** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 | Continued From page 5 S9999 asked how the CNAs are informed of care V6 replied "It's kind of a habit. There's a care card inside the closet that lets them know how to transfer. I did not give her verbal report. She's known (R1) and we've worked with (R1) for a long time. V5 is one of the regular CNAs on that unit. The care card indicated that (R1) is a mechanical lift transfer with two people, which means two staff has to transfer (R1) with the mechanical lift." When asked what risk factors R1 has, V6 replied "(R1) is totally dependent on us. (R1) has not refused care." V6 stated when she entered the room (on 3/19/19), "(R1) was in bed with the sling to the mechanical lift under R1's back and R1's arm next to the pillow." V6 added "(R1) had по pain prior to this point, (R1) will definitely say when (R1) is in pain. (R1) rarely is. There was no report from the previous shift that (R1) had pain and I saw (R1) in the dining room. There was no pain until (V5) came and told me. I attempted a little ROM (Range of motion) and (R1) stated it hurts, so I didn't move it too much." V6 stated she notified V4 (Nurse Practitioner/Primary Care Provider) who ordered X-rays. V6 stated the results showed acute fracture. On 3/21/19 at 2:27 PM, V7 (Nurse on Duty) stated "I've worked with (R1) for 3 years." V7 stated "staff are made aware of resident's care through report and care cards which are in the closet that tells you what kind of transfer a resident needs. (R1) is mechanical lift transfer. and has been since I can remember. (R1) has been mechanical lift transfer since (R1) has been here. The policy is for 2 people to use the mechanical lift for transfer. It's not a new policy. (R1) has a right hemiplegia from CVA (Cerebral vascular accident), right side is flaccid and (R1) is unable to move it. (R1) had no recent complaints

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6012835	B. WING			C 22/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	1 331		
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S9999	Continued From pa	ge 6	S9999	-			
29999	of pain in that arm. the shoulder that's in been a while ago. (pain prior to the wenurse communicate "that's in their orient something changes care card." On 3/21/19 at 2:37 Istated she is respordanted she is respordanted. V8 stated "(I (R1) had a prior fract herself. (R1) is transtwo persons. That I before I was even in on that for years, sinhow CNAs are maddreplied "They know in the locker. There hallway that has the tell how somebody in places they can look over a year." V8 stated "The policy for person minimum. It orientation and routi in-servicing." When the resident's transfecare card in the closs screens that they do care of (R1) for over (V5) and she just toll herself which she diestated V5 did not foll stated V5 did not followed.	(R1) had an old fracture in why (R1) is on Tylenol. That's (R1) was not complaining of ekend." When asked how the escare to the CNAs, V7 stated tation and on care cards. If it, restorative writes it on the PM, V8 (Restorative Nurse) insible for making resident care R1's) right side is flaccid and cture. (R1) can't move by esferred via mechanical lift per has been in effect since in restorative. (R1) has been ince admission." When asked e aware of transfer status, V8 by the care card. It is always es also a touch screen in the ecare plan which would also is transferred. There are two kell to the care determined at transfer eated "We had a transfer					
	the care card in R1's						

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED C IL6012835 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE **ROSEWOOD CARE CENTER OF JOLIET JOLIET, IL 60435** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 7 S9999 TRANSFER: total lift (2). On 3/22/19 at 9:20 AM, R1 was awake in bed visiting with V9 (Family Member). R1 had a soft cast over the RUE (right upper extremity) which was in a sling. When asked about the extremity. R1 only groaned. V9 stated "I was with (R1) at breakfast. (R1) did not complain of pain prior to the CNA putting (R1) back to bed. The CNA came to the dining room and she had an attitude. She was talking aggressively and was upset because (R1) was not finished eating. Then she put (R1) to bed and then (R1) started complaining of arm pain. The emergency room doctor said it was trauma. You should've seen it, it was swollen all the way up." On 3/22/19 at 1:14 PM, V4 (Nurse Practitioner/Primary Care Provider) stated the facility called her when R1 complained of pain and she ordered the X-ray which showed a fracture. V4 stated "the fracture is related to trauma because (R1) didn't have pain there before that transfer. (R1) was not complaining of arm pain prior to the transfer. (R1) had a previous fracture but at a different location." V4 stated "because (R1) had a prior fracture I would expect the facility to give extra care to that side. to be extra careful. I would expect them to follow the policy, the care plan and the care card." V4 stated risk factors for R1 sustaining a fracture/injury included prior fracture, CVA, right

age."

hemiplegia, and muscle wasting. V4 stated "R1's road to recovery will take longer because of R1's

The Limited Lift Guest Handling Policy reads: Policy- To ensure safe resident transfers and a safe working environment for direct care staff. mechanical lifting devices will be utilized

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ___ COMPLETED C IL6012835 B. WING _ 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3401 HENNEPIN DRIVE **ROSEWOOD CARE CENTER OF JOLIET JOLIET, IL 60435** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 8 S9999 according to an established facility protocol. Protocol- Transfer status will be noted on the Resident's Care Plan and in a designated location established by the facility. The designated location for this facility is inside closet door. V5's signature was on the sheet. The policy titled Total Resident Transfers Using Mechanical Lifts reads: total mechanical lifts require a minimum of 2 trained staff members to complete a resident transfer. The resident's care plan must be followed with regard to the type of transfer as well as the number of staff members required to complete the transfer. (B)

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